Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-1519-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JANUARY 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider, Dr. Lopez has attached dictations for each date of service. He has outlined key components regarding the patient's office visit. All of this documentation was sent in for reconsideration to the carrier several times. This is an approved case with all other claims being paid in full."

Amount in Dispute: $346.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99214 for date 5/14/14. Review of the requestor's documentation reveals a problem focused history and a problem focused exam, which correlates to CPT code 99212. The requestor also billed code 9080 for the same date. The DWC-73 of 5/14/14 is the same as the one of 4/14/14. (Attachment) For these reasons Texas Mutual declined to issue payment for date 5/14/14. The requestor billed code 99214 for date 6/26/14. Review of the requestor's documentation reveals a problem focused history and a problem focused exam, which correlates to CPT code 99212. For this reason Texas Mutual declined to issue payment for date 6/26/14."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2014 June 26, 2014	CPT Code 99214 Office Visit	$165.84/ea	$0.00
May 14, 2014	CPT Code 99080-73 Work Status Report	$15.00	$0.00
TOTAL		$346.68	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-P12-Workers' compensation jurisdiction fee schedule adjustment.
   - CAC-150-Payer deems the information submitted does not support this level of service.
   - 248-DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5.
   - 890-Denied per AMA CPT code description for level of service and/or nature of presenting problems.
   - CAC-193-Original payment decision maintained. Upon review it was determined that this claim was processed properly.
   - 891-No additional payment after reconsideration.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Does the documentation support billing of CPT code 99214? Is the requestor entitled to reimbursement?
2. Is the requestor entitled to reimbursement for work status reports, CPT code 99080-73?

Findings

1. The respondent denied reimbursement for the office visit, CPT code 99214 based upon reason codes "CAC-150" and "890."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

   The respondent maintains denial of payment stating "Review of the requestor's documentation reveals a problem focused history and a problem focused exam, which correlates to CPT code 99212."

   A review of the submitted medical reports finds that the requestor did not document at least 2 of the 3 key components to support billing CPT code 99214 on the disputed dates of service. As a result, reimbursement is not recommended.

2. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

   28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

   28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

   28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report:
   (1) after the initial examination of the employee, regardless of the employee's work status;

   (2) when the employee experiences a change in work status or a substantial change in activity restrictions."

The respondent submitted copies of the work status reports dated April 24, 2014 and May 14, 2014, the comparison shows that requestor did not support billing May 14, 2014 report per 28 Texas Administrative Code §129.5 (d)(2); therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/27/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.